UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
WESTERN DIVISION

LEAH M. COAN, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C04-4040-MWB **REPORT AND RECOMMENDATION**

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I. INTRODUCTION

The plaintiff Leah M. Coan[1] ("Coan") appeals a decision by an administrative law judge ("ALJ") denying her applications for Title II disability insurance ("DI") and Title XVI supplemental security income ("SSI") benefits. Coan claims the ALJ erred in failing to find her credible, and failing to consider the impact of her "need to lie down as well as alternate between sitting and standing." (Doc. No. 8 at 5)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On July 31, 2001, Coan protectively filed applications for DI and SSI benefits, alleging a disability onset date of March 1, 2001.[2] (R. 100-102, 489-91; *see* R. 31). Coan alleged she was disabled due to chronic back pain and chronic Hepatitis C. (*See* R. 116) Her applications were denied initially on October 30, 2001. (R. 74-75, 83-86, 492-96[3]). Coan filed a request for reconsideration on January 10, 2002. (R. 87) Her applications were denied upon reconsideration on May 4, 2002. (R. 88-92, 497-502)

On July 24, 2002, Coan requested a hearing (R. 93), and a hearing was held before ALJ Lauren R. Mathon on November 4, 2003, in Sioux City, Iowa. (R. 29-69) Coan was represented at the hearing by attorney Jay E. Denne. Coan testified at the hearing,

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[1]At the ALJ hearing, Coan stated she had changed her name after a divorce, back to her maiden name of "Becker." However, she did not move to amend her Complaint in this matter to reflect the name change, so the court will continue to refer to her as "Coan."

[2]Coan filed previous applications for DI and SSI benefits on March 31, 2000. (R. 97-99, 475-81) Those applications were denied on June 23, 2000. (R. 70-73, 482-87) There is nothing in the Record to suggest Coan appealed the denial of her prior applications.

[3]It appears Coan was not notified of the October 30, 2001, denial of her applications until November 23, 2001, although another undated notice of the denial of her DI application appears in the record. (*See* R. 79-82)

as did her 18-year-old daughter, Rae Anna Coan. No vocational expert testified at the hearing.

On January 12, 2004, the ALJ ruled Coan was not entitled to benefits. (R. 14-22) Coan appealed the ALJ's ruling, and on April 10, 2004, the Appeals Council denied Coan's request for review (R. 9-11), making the ALJ's decision the final decision of the Commissioner.

Coan filed a timely Complaint in this court on June 1, 2004, seeking judicial review of the ALJ's ruling. (Doc. No. 2) In accordance with Administrative Order #1447, dated September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Coan's claim. Coan filed a brief supporting her claim on August 30, 2004. (Doc. No. 8) The Commissioner filed a responsive brief on October 1, 2004 (Doc. No. 9).

The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Coan's claim for benefits.

B. Factual Background

1. Introductory facts and Coan's hearing testimony

At the time of the hearing, Coan was thirty-nine years old. (*See* R. 97) She was 5'1" tall and weighed about 156 pounds. She indicated she was divorced, and she had two children, ages eighteen and fourteen. (R. 34-35) As of her alleged onset date of March 1, 2001, she was living in a one-level mobile home in Hubbard, Nebraska, with her husband and children. She and her children had lived there for eight years. She indicated her husband left in 2001, and she continued to live in the mobile home with her children for another eighteen months, until the spring of 2003, when she moved in with

her mother in Sioux City, Iowa. Coan stated her mother's home also is a single story. (R. 46-48)

Coan stated she had obtained her GED when she was twenty-one years old, and had not had any further education since that time. (R. 34-35) She started working when she was twelve years old, and she spent most of her life working as a waitress, bartender, dishwasher, and cook. She also worked for MCI as a telemarketer in 1989 and 1990, and as a meat packager at a packing house. (R. 34-35) In the telemarketing job, she was able to sit or stand at will, and she used a computer. She left the job to go to work at Hungry's restaurant in Dakota City, Nebraska, which was closer to her home. (R. 54-55) She worked for ten years as a bartender and waitress at Hungry's. She stopped working at Hungry's in June 2000, and has not worked since then. (R. 36, 49) According to Coan, her doctor told her she could not work any longer. (R. 49-50)

Coan stated she could no longer work in the restaurant jobs because all of them require constant standing with long periods of time in between breaks. She stated the packinghouse job was the same, requiring too much standing. Although the telemarketing job was primarily sitting, she indicated she can only sit for twenty minutes at a time or she will experience excruciating pain. (R. 44-45) She stated she looked into some jobs in the spring of 2001, such as part-time work at a store, but they would not hire her because, due to pain, she could not work the hours they required. (R. 45, 50-51) She has not applied for any jobs since the spring of 2001. (R. 51) To support her family, she received Aid to Families with Dependent Children from July 2001, until her son moved in with his father in the spring of 2003. In addition, her daughter contributed income to the household. (*Id.*) Coan indicated she received $102 per month in child support beginning in the summer of 2003, but she had not received child support prior to that time because she "never pressed any issues." (R. 52)

Coan stated she "had a crushed disc" at S1, L5 in her lower back. She stated, "They had to do surgery. Two of them and that was – it was just a herniated disc and the sciatic nerve, damage done to that from scar tissue and surgeries that makes it so that I'm not capable of doing a lot these days." (R. 37) She stated her back problems began in about 1992, when she lifted her father while trying to help extricate him from a tractor. Coan stated she lifted her father and then she dropped to her knees and crawled to the road. Coan said she has had back problems ever sine then. She attempted to resolve her pain through chiropractic treatments, and when that failed to work, Steven J. Meyer, M.D. performed surgery on her back.

Coan stated she saw Dr. Meyer for follow-up until August 2003, which was the last time she had seen him. According to Coan, Dr. Meyer could do nothing further for her, and he had referred her to pain management specialists for further care. (*Id.*; *see* R. 43) She still planned to see Dr. Meyer for occasional checkups, as needed. (R. 43) She indicated she had seen Dr. Bruce Keppen, a pain specialist at Mercy Medical Center, for awhile, and he "tried to burn the nerve in the right leg and prescribed medication as well." (R. 56) She saw Dr. John Cook at Siouxland Surgery Center Pain Clinic for a year-and-a-half, until the spring of 2003. He gave her epidurals or shots. (R. 55-56) At the time of the hearing, she was seeing Dr. Swanson at Mercy Medical Center. She stated Dr. Swanson is a general practitioner rather than a pain specialist, and she was referred to him because she has no insurance. He was treating her for pain and monitoring her overall health. (R. 57)

For her Hepatitis C, Coan stated she went through six months of treatment with nurse-practitioner Carole D. List at Mercy Medical Center. (R. 58; *see, e.g.*, R. 216-19) According to Coan, the treatment did not put the disease into remission, and she had not been back to have it rechecked in awhile. Her symptoms from the Hepatitis C include

high blood pressure and occasional heartburn, which she controls with medication. She stated her primary disability claim is related to her back pain. (R. 58)

Coan described her daily routine as follows:

> I get up in the morning and I have coffee. I read my Daily Bread book and sometimes it's very difficult to get up out of bed due to the pain. My leg sometimes is numb. To use the bathroom is difficult also. That's the morning, you know, I'm trying to get up and get things moving. I take medication and usually that does help it subside somewhat for a little while. It's hard to – difficult. Some days are good; some days are bad. I can sometimes get laundry and sometimes I can't. You know, there's days I can't let the dog out. My kids have been my right hand for everything . . . the last few years. It just depends on the day. . . . [S]ome days are good and some days are bad.

(R. 38) Coan indicated she sometimes tries to cook a little. She may take a shower, but then sometimes she will "lay back down because of the pain." (R. 59) She reads, which she enjoys. (R. 59-60) She occasionally helps her mother fold laundry or prepare a meal. She stated her mother does not work and is at home during the day. Coan stated there are two dogs at the house. She feeds them and lets them outside, but her father walks them. (R. 60-61)

Coan stated her daily routine was similar in the summer of 2001, after her alleged onset date. She stated her daughter and son helped her a great deal on a daily basis and "did everything for [her]." (R. 48) Her daughter drove her places, cleaned, and did the cooking. Her children were not involved in sports or other school functions, so Coan did not attend those types of events. She noted she might have attended a Christmas program in 2001, but could not recall attending any other school-related functions. (*Id.*)

Regarding her physical capabilities, Coan stated she has to alternate between sitting and standing at least every twenty minutes or she will experience "[e]xcruciating

pain" in her back and legs, down into her toes. She stated she "can feel it in the bone and they're like spasms[,] shooting pains." (R. 38-39) She indicated the pain shoots down both legs, usually alternating between the left and right sides but sometimes on both sides at once. (R. 39) The pain will subside if she lies down, but she stated she has to take sleeping medication, lay on her side, and prop up her leg with a pillow just to get comfortable. She stated she is unable to lay on her back or her stomach without experiencing a lot of pain, both while she is lying down and when she gets up. (R. 40) Coan indicated family members assist her in getting around, and she has been using a cane to get around her house. (*Id.*)

Coan stated she can walk for two-and-a-half to three blocks before she has to stop due to pain. She uses a cane and takes her time. She indicated she does not go to the grocery store "because it's just almost a hassle." (R. 43) According to Coan, Dr. Meyer placed her on a five-pound lifting restriction. (*Id.*) She stated she can ride in a car for short distances, such as across town or from South Sioux City, Nebraska, to Sioux City, Iowa, but after about twenty minutes, she has "sat long enough." (R. 44)

Coan indicated she takes the muscle relaxer cyclobenzaprine three times daily to control spasms, and she also takes pain medication every four to six hours. According to Coan, she used to take Oxycontin, but she had switched to methadone or hydrocodone. She also takes Ibuprofen 800 mg three times daily for inflammation, and Trazodone to help her sleep at night. She stated she can only sleep for about two hours at a time even with pain medication, and then she will have to get up and move around. She indicated that during the night she uses the restroom frequently, she is very uncomfortable, and she does not sleep well. (R. 40-41)

Coan stated her pain has gotten worse since her alleged onset date in March 2001. Her first surgery was on May 1, 2000, and she had another surgery in January 2001,

when, according to Coan, doctors "had removed some of the bolts" from her back. (R. 49)

At the time of the hearing, Coan was in custody in Dakota County, Nebraska, and she had been in custody for twenty-five days. She apparently was serving time on a December 2002 charge of possession of methamphetamine. She stated she had tried methamphetamine a couple of times in 2002, with a boyfriend. According to Coan, she quit using methamphetamine and tried to get into drug treatment in the spring of 2003, but she was unable to get into treatment because she had no insurance. She stated she "attended some AA meetings and did some extra Bible reading" to quit using. (R. 45-46, 53) She was accompanied to the hearing by a Dakota County Sheriff's Deputy. (*See* R. 31)

Coan indicated she has been arrested twice in her life. The other arrest was for possession of marijuana, in 1986. She was fined and put on probation for two years. At the time of the hearing, Coan indicated she was clean and sober, and she had not used any illegal drugs since the spring of 2003. (R. 52, 54)

While she was in custody, Coan's activity was limited to reading, walking around a bit, and perhaps taking a shower. She did not participate in any type of exercise program and did no work at the facility, such as helping in the kitchen. (R. 60)

After the hearing had been going on for about half an hour, Coan stated she would like to get up and move around because her leg and toes had gone numb. She indicated that was typical of what happens when she sits for about half an hour at one time. (R. 61)

2. Rae Anna Coan's hearing testimony

Coan's 18-year-old daughter, Rae Anna Coan ('R. Coan"), testified she lived with her mother during her entire life until about a month prior to the hearing, when Coan began serving her sentence. At the time of the hearing, R. Coan was living alone in Hubbard, Nebraska, and she was working at a restaurant as a waitress. (R. 63-65)

She stated that five years prior to the hearing, her mother felt much better and was not taking pain medication. She participated in family activities, went shopping with her daughter, traveled with the family on vacations, and the like. R. Coan stated her mother no longer can do those things because of her back pain. She stated her mother "hardly can do anything." (R. 65) She stated that before her mother went to jail, her mother's daily routine consisted of getting up, having coffee, maybe doing a couple of loads of laundry, and then lying back down. She stated her mother can stand or sit for no more than twenty minutes at a time, and Coan's condition had worsened progressively since Coan quit working at Hungry's. (R. 66)

R. Coan stated that when she was still in school, she took a bus to school. If she had an appointment, Coan would pick her up and drive her, but according to R. Coan, her mother could not drive very far because she would get spasms in her legs. She stated her father usually drove the children when they needed to go somewhere. (R. 66)

R. Coan stated she or her younger brother would do the vacuuming. Her mother helped with dishes, laundry, and other small jobs that would allow her to sit or stand as necessary. Her mother might do the dishes but she would sit down and take breaks. (R. 67) R. Coan has observed that her mother sometimes has difficulty sleeping due to back pain. If her mother is able to get to sleep, she sometimes sleeps into the afternoon. She noted her mother sometimes takes care of the two pit bull dogs, feeding and watering them and letting them outside into a fenced area, but R. Coan had been the dogs' primary

caretaker. Since she stopped living with her mother, R. Coan stated she still makes sure the dogs are taken care of. (R. 68)

3. Coan's medical history

The record in this case includes Coan's medical records dating back to July 1999. In its initial evaluation of Coan's prior applications for benefits, the Social Security Administration considered doctors' reports from July 13, 1999, through May 1, 2000 (*see* R. 79), and upon reconsideration of the prior applications, the Administration considered additional medical records from January and February 2002. (*See* R. 88) The Administration agrees the evidence shows Coan has degenerative disc disease of her lower back, for which she underwent surgery in May 2000. (*Id.*; R. 18) In the present case, the ALJ found Coan had "a history of lumbar spondylosis resulting in a laminectomy, discectomy and fusion at L5-S1 in May 2000[.]" (R. 18; *see* R. 257) The Administration also agrees Coan had increasing pain and discomfort after her surgery, and she underwent another surgery of her lower spine on January 14, 2002. (R. 88) Where the parties differ is in their assessment of the degree of limitations Coan suffers as a result of her back surgery. Both Coan, in her brief (Doc. No. 9), and the ALJ, in her opinion, begin their review of Coan's medical history in January 2001. (*See* R. 18; Doc. No. 9, at 3) The court, therefore, will begin its review around the same time frame.

Records indicate Coan had been doing well since her May 2000 surgery, until November 21, 2000, when she fell while getting some groceries out of her car. (R. 427) She was diagnosed with "some irritation of the effusion mass and probably of the sacroiliac joint at the site of the bone harvesting," and she was treated with a Medrol dose pack. (*Id.*; *see* R. 429, entry dated 8/29/2000) Records also indicate that since her May

2000 surgery, Coan had been taking pain medications on an ongoing basis, including, at various times, Ultram, Darvocet, Vioxx, and sacroiliac injections. (*See* R. 426-32)

On January 4, 2001, Coan went to the emergency room complaining of "significant increase in her pain including left leg pain." (R. 385) Steven J. Meyer, M.D. noted Coan was "obviously uncomfortable," but "in no apparent acute distress." (*Id.*) His examination revealed tenderness along Coan's lower lumbar spine, positive straight-leg-raising on the left, and diminished reflexes in both knees and slightly in both ankles, but she exhibited excellent motor strength in both lower extremities. X-rays of her lumbar spine were unremarkable, and Dr. Meyer ordered a myelogram and CT scan for the next day. (R. 385-86)

Coan underwent the myelogram and CT scan on January 5, 2001. The CT scan showed mild facet hypertrophy at L4-5, but the tests otherwise were unremarkable. (R. 387-89) Coan did, however, develop a lumbar puncture headache from the myelogram, and she was treated with an epidural blood patch at L4-5 under fluoroscopy on January 9, 2001. (R. 390-92)

On January 18, 2001, Coan slipped and fell on ice in a parking lot. She landed "directly upon her back," and experienced acute pain in her right lower back, with no radiation of pain down her leg and no lower extremity weakness. (R. 411) The next day, she saw Scott A. Holtz, M.D. at Dunes Family Medicine for evaluation of her back and buttock pain. He found point tenderness over Coan's right sacroiliac joint and right paraspinous lumbar musculature. Dr. Holtz diagnosed her with a muscle strain in the

right lumbar region. He prescribed Flexeril and Vicoprofen, and "[a]dvised her to sleep in the semi-Fowler position."[4] (*Id.*)

She returned to see Dr. Holtz for follow-up on January 23, 2001, complaining of continued knee pain and lower back pain. (R. 410-11) She stated her knee pain was improving daily but her lower back pain essentially was the same. The doctor noted some ecchymosis around her knee, but no other physical findings related to her knee. She exhibited tenderness in the paraspinous lumbar musculature and some tenderness along the spinous processes but "no obvious marked tenderness." (R. 410) X-rays were negative. (R. 412-13) Dr. Holtz started her on Vicodin for pain, and directed her to continue taking Ibuprofen. He instructed her to return for follow-up in one week. (R. 410)

Coan saw Dr. Holtz again on January 30, 2001. She reported that her back was getting better slowly, and she had no neurological symptoms of her lower extremities, no muscular weakness, and no further injury. She expressed concern about her knee, which continued to bother her, although it was not preventing her from walking short distances. She also complained of some pain in her left elbow, which also had been injured in her fall. She noted she was trying to return to work and was having difficulty carrying things. She denied numbness or tingling in her arms, shoulders, or hands. Examination of her back revealed continued muscle tenderness, although this was improved from previous exams. Her left knee was tender along the lateral aspect of the patella and continued to show some ecchymosis. She had normal flexion and extension of her left elbow, but she could not hold her biceps flexed against resistance. The doctor opined she could not hold more than five to ten pounds without difficulty. X-rays did not show a fracture, and he

[4]In the Fowler's position, the head of the patient's bed is raised 18 to 20 inches, and the knees also are raised. *See Dorland's Illustrated Medical Dictionary* 1341 (27th ed. 1988).

diagnosed her with a probable boney bruise. He continued her on Percocet for pain and Ibuprofen. He directed her to return for follow-up in one week, and to stay off work until then, noting her job required a lot of walking and lifting. (R. 408-09)

Coan returned for follow-up on February 6, 2001. (R. 407-08) She felt she could return to work. She stated her back was still somewhat tender but was improving slowly. Her left elbow was much improved with better mobility and decreasing pain. Her left knee was still quite painful, but she stated she would ambulate without difficulty as long as she did not have to bear weight directly on the knee. She was still taking Percocet three to four times daily. Dr. Holtz noted Coan's lumbar sprain was improving, but he "[w]ould not expect her to get back to completely normal as she was not completely normal prior to this incident. She has underlying disc [disease] and has had recent surgery. Would expect her to be tender there and she lives with a certain [amount] of pain on a daily basis anyway. But no neurological [symptoms] and probably no long term problems from this fall as well." (R. 407) The doctor released Coan to return to work for twenty hours per week, but no longer than four hours per shift. He directed her to return for follow-up in one month. (*Id.*)

Coan saw Dr. Holtz again on February 26, 2001. She stated she was still having problems with her left knee, and it had begun "catching a little bit," and making a popping sound frequently, especially when she went from a sitting to a standing position. (R. 407) She stated her left elbow also was still causing her quite a bit of discomfort, and she was unable to lift anything without a lot of pain. Her back was "pretty stable," possibly "back to her baseline." (*Id.*) Coan was still taking Percocet three to four times daily for pain. Upon examination, Dr. Holtz noted marked tenderness in Coan's elbow, with decreased flexion and strength of her wrist and finger. He ordered an MRI of her elbow to rule out internal derangement of the ligaments. Regarding Coan's knee, the

doctor expressed some concern about possible cartilage damage, and he also ordered an MRI of Coan's knee. (R. 406-07) The MRIs of Coan's elbow and knee were performed on March 2, 2001, and both were normal. (R. 397-98; *see* R. 406) Dr. Holtz referred Coan to Dr. Meyer for further treatment. (R. 406)

Coan called Dr. Holtz's office on March 23, 2001, to request a refill of her Percocet. She was told she could not obtain further refills until she saw Dr. Meyer. Coan saw Dr. Meyer on April 3, 2001. His examination of Coan's elbow revealed significant tenderness along the medial epicondyle, but good range of motion, no effusion, and excellent medial and lateral stability. Coan experienced increased pain with wrist and digital flexion. Her left knee was tender along the patella and the anterior prepatellar fat pad, but she had good medial and lateral stability, and negative McMurray's test for pain.[5] Dr. Meyer recommended an injection of Coan's elbow, ice, and physical therapy. For her knee, he recommended ice and anti-inflammatory medications. He directed Coan to return in three to four weeks; however, she did not see Dr. Meyer again until September 2001. (R. 425-26; *see* R. 423-24)

Coan called Dr. Meyer's office to report on her condition on April 5, 2001. (R. 425) She called on April 24, 2001, for a medication refill, but the doctor's notes do not indicate what medication she requested or whether or not the prescription was refilled. (R. 424)

On May 4, 2001, Coan called Dunes Family Medicine to request pain pills. She stated she had twisted her back. Dr. Scott prescribed Lortab. (R. 414) On May 8, 2001, Coan saw Dr. Holtz complaining of back pain. Coan stated she and her husband had been involved in an altercation, she was pushed backward, and she fell into a doorjamb.

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[5]McMurray's test uses rotation and manipulation of the knee to check for a meniscus tear. *See, e.g.*, http://www.latrobe.edu.au/podiatry/Knee.html (visited 3-25-05).

She reported pain in her right sacroiliac region. The doctor also noted Coan had a history of anxiety in the past. He noted she had been doing well prior to this incident, but she was "very anxious today, very emotional, crying throughout the interview." (R. 414) Coan was resistant to the doctor's suggestion that she try an antidepressant medication. Upon examination, he noted Coan had marked tenderness over the right sacroiliac joint, but no real spinous process tenderness. He prescribed Motrin and Lortab for her pain. He also prescribed Clonazepam due to Coan's acute upset, and Ambien to help her sleep. (R. 414, 405)

Coan returned to see Dr. Holtz on May 15, 2001. She reported continued pain in her right lower back, although less tenderness than at her previous visit. She also reported some urinary frequency. Upon examination, the doctor appreciated a 3 cm. mass in Coan's right paraspinal muscles in the lumbar region, and marked tenderness. He diagnosed her with a right paraspinal muscle hematoma. He prescribed Vicoprofen, warm heat, and massage to the area. He advised her to watch the urinary frequency, which had just begun, and to return on an as-needed basis. (R. 404-05)

On May 21, 2001, Dr. Holtz refilled Coan's prescription for Ibuprofen 800 mg three times daily, but he declined to refill her Vicoprofen. (R. 403-04)

Coan saw Dr. Holtz again on May 30, 2001. She stated her back pain had worsened markedly over the previous two days, and she was experiencing sharp, shooting pains down her right leg "and severe back pain to the point where she [was] unable to work." (R. 403) She related one episode of bladder incontinence, but the problem had not recurred. The doctor diagnosed her with radiculitis/neuritis of the lumbar region. He told her to stay off work for a couple of days, and he ordered another MRI of her back. He told her to call him immediately if she had any further bowel or

bladder incontinence, stating that would be "a surgical emergency." (*Id*.) He prescribed Ibuprofen for pain, and told Coan to return as needed. (*Id*.)

She returned to see Dr. Holtz on June 25, 2001. (R. 403) Coan had cancelled her scheduled MRI because she felt her back was improving. However, she reported that she had slipped and reinjured her back the previous week, and she was experiencing severe pain and had been bedridden for three days. She stated she had missed work which could lead to her being fired. The doctor had given her a few Vicoprofen over the weekend, and Coan stated her pain had improved and she was getting around better. Upon examination, the doctor noted marked tenderness over her left sacroiliac joint, but other wise a normal examination. He diagnosed her with lumbar radiculopathy and "a hint of sacroilitis." (R. 400) He prescribed continued Vicoprofen every six hours for pain and inflammation. He directed her to stay off work "and go on unemployment for the next week or two and get an MRI done on her back and see if anything acute in nature." (*Id*.)

Coan underwent an MRI of her lumbar spine on July 18, 2001. (R. 401-02) Positive findings included the following: "Ventral enhancing epidural fibrosis produces mild mass effect on the thecal sac surrounding a mildly edematous right L5 nerve root"; and "Mild L4-5 facet hypertrophy, slightly increased since 3-00." (*Id*.)

Dr. Holtz discussed the MRI findings with Coan on July 23, 2001. He prescribed a Medrol dose pack, and refilled Coan's Vicoprofen, which she was taking four times daily along with ice, icy hot, and warm baths. Coan advised Dr. Holtz that she had applied for unemployment and Social Security benefits, but she wanted to know if the doctor thought she could return to work with her symptoms. Dr. Holtz advised Coan to wait until further evaluation by Dr. Meyer before she resumed working. (R. 399) Dr. Holtz refilled Coan's Vicoprofen again on August 10, 2001. (R. 399)

Coan missed her appointment with Dr. Meyer on August 29, 2001 (R. 424), and the appointment was rescheduled for September 12, 2001. When she saw Dr. Meyer on that date, Coan reported that she was still "having a good deal of pain" in her low back, both buttocks, and legs. (R. 423) Dr. Meyer noted Coan's MRI "demonstrated some probable neurofibrosis around the right L5 nerve root . . . [and] some progressive deterioration of the L4-5 facets." (*Id.*) His examination revealed "positive straight leg raising bilaterally," and "tenderness of the buttock to palpation in the sciatic notch." (*Id.*) He recommended an epidural flood, continued use of Vicoprofen, and the addition of Flexeril for five days for Coan's muscle spasms. He directed her to return for follow-up in four to six weeks. (*Id.*)

Coan went to see Dr. J.E. Cook for the epidural flood on September 13, 2001. (R. 434-35) Dr. Cook noted that an epidurogram showed "very little passage of dye past L5-S1 which probably represents scar tissue." (R. 434) He noted further that Coan became uncomfortable due to pressure after very little injection, which he opined "probably demonstrates that there is very little epidural space secondary to scar tissue." (*Id.*) He suggested she return for follow-up in two weeks, with re-injection if she showed continued improvement. (R. 435)

Coan returned to see Dr. Cook on September 27, 2001. She reported "absolutely no relief" from the previous injection, and in fact, she stated she "felt worse for four to five days after her injection." (R. 433) She stated she was unable to get out of bed one day even though she was taking Vicoprofen and other narcotics for pain. Dr. Cook opined Coan had scarring that would prevent her from benefitting from further steroid injections. He recommended continued conservative treatment with pain medications, and follow-up with Dr. Meyer. (*Id.*)

Coan returned to see Dr. Meyer on October 24, 2001. She reported continued severe pain in her right leg and an irritable hip. She exhibited tenderness to palpation, and positive straight leg raising. Dr. Meyer planned to wean Coan off of narcotic pain medications, order another nerve root injection, and see Coan again in one month. He noted that if she continued to have symptoms, he might consider EMG/NCV testing. (R. 457)

Tom Chael, M.D. reviewed Coan's records and completed a Physical Residual Functional Capacity Assessment form on October 30, 2001. (R. 441-50) He opined Coan could lift twenty pounds occasionally and ten pounds frequently; stand, walk, or sit for about six hours in an eight-hour workday, with normal breaks, and push and/or pull without limitation. He opined she would have occasional problems with climbing, balancing, stooping, kneeling, crouching, and crawling, but she would have no manipulative, visual, communicative, or environmental limitations. In his notes, Dr. Chael indicated the following:

> Claimant told Dr. Holtz['s] office that Dr. Keppen[] asked her to get a work release . . . [and] that he wanted her off work one week 3/3/00. Dr. Keppen disputed this [and] expressed concerns about need for one doctor to manage narcotics. Some complaints of pain . . . but these occur[red] following acute injury. Partial credibility. Symptoms are evidence but bulk of evidence supports ability to do light work. Past employer attributes poor dependability to marital problems, says she called in sick but actually took a trip to Colorado. Not a forthright reporter.

(R. 446[6]) Dr. Chael also noted Coan had been limited to five to ten pounds lifting following her second acute elbow injury, but the restriction was not ongoing and she had

[6]The court has not located evidence in the record that Coan had seen Dr. Keppen prior to Dr. Chael's records review.

been released to twenty hours per week on February 6, 2001. (R. 447) Another doctor (name illegible) reviewed Dr. Chael's findings on November 7, 2001, and concurred in his assessment. (R. 449-50)

Coan saw Bruce W. Keppen, M.D. on November 8, 2001, for treatment of her L5 nerve root block. Upon fluoroscopy, Dr. Keppen determined "the right nerve root did appear to be blocked by prior surgery." (R. 439) He therefore "elected to go through the left L5 neural foramina . . . to make sure the dye spread over to both nerve roots via transforaminal epidural." (*Id.*) Coan tolerated the procedure well. She was discharged in stable condition, with a prescription for Klonopin. He also called Dr. Meyer's office to let them know Coan was running low on her pain medications and Dr. Keppen had directed her to get the refill from Dr. Meyer. (*Id.*)

Coan returned to see Dr. Meyer on November 28, 2001. He noted she was still having a lot of pain in her back and her left leg. She described her leg pain as "electrical in nature, worse with certain positions in her back." She had normal strength and reflexes, and negative straight leg raising. Dr. Meyer ordered an EMG/NCV to rule out any definitive radicular pathology. (R. 456)

Coan missed her scheduled appointment for the EMG/NCV due to stomach flu. She saw Dr. Meyer on December 12, 2001, with continued complaints of excruciating pain around her buttocks, sacroiliac area, and extending into her thigh. Her pain worsened with activity. She had not experienced any significant relief from the injections or medication. Dr. Meyer opined she could have some scarring or neural element encroachment by the hardware in her back, and he rescheduled the EMG/NCV testing. (R. 455)

When Coan saw Dr. Meyer on December 19, 2001, he noted she had undergone the EMG/NCV testing, which demonstrated "some subtle right L5 nerve root impinge-

ment" at the location of the scar tissue buildup, "and possible nerve root encroachment on the basis of pedicle screw fixation." (R. 454) Dr. Meyer expressed some skepticism about Coan's "overall desire to improve and to comply," but because of Coan's ongoing pain, the doctor nevertheless recommended she have the hardware removed and exploration of the right L5 nerve root. Upon examination, Coan exhibited "significant tenderness to the right sacroiliac joint, buttock, and greater trochanteric region to palpation"; "positive straight leg raising bilaterally, right more acutely than left"; and excellent motor strength "with encouragement, although she does have some slight weakness of right knee extension, . . . primarily limited by pain." (*Id.*) She had diminished reflexes of both knees, and a trace in both ankles. "X-rays reveal what appears to be a solid arthrodesis, stable L5/S1 fusion." (*Id.*) In recommending the surgery, Dr. Meyer advised Coan he would not prescribe any narcotic medications for her beyond six weeks following her surgery. Coan agreed to that restriction, and they agreed to schedule the surgery. (*Id.*)

On January 14, 2002, Dr. Meyer performed surgery on Coan to remove the hardware and to perform decompression of the right L5 nerve root. Her pre-operative and post-operative diagnoses were "Status post L5-S1 posterior facet spinal fusion with instrumented pedicle screw hardware; right L5 nerve root encroachment." (R. 451) Dr. Meyer noted the "hardware was removed without difficulty. The S1 pedicle screw on the left had evidently previously been broken and the distal aspect was felt to be stable and was left in place. Once the hardware was removed the fusion was assessed and found to be completely stable." (*Id.*) He excised the scar tissue from the thecal sac and found the right L5 nerve root to be "encased in dense scar tissue and also to have significant pressure from an osteophyte emanating from the lateral gutter just inferior to the L5 pedicle." (*Id.*) He also noted "significant synovitis and synovial hypertrophy of

the right L4-5 facet joint," and dense adherence of the nerve to the scar tissue with "significant encroachment of the origin of the L5 nerve root on the right side." (*Id.*) He dissected the scar tissue and opened the neural foramina. (*Id.*) Coan tolerated the procedure well and she was discharged with a prescription for prophylactic antibiotics. (*Id.*)

At a follow-up visit on January 30, 2002, Dr. Meyer noted Coan was "doing amazingly well." (R. 453) She had negative straight leg raising, good strength, and normal reflexes. Her incision was healing well. He recommended she increase her activities progressively and return for follow-up in one month. (*Id.*)

On February 19, 2002, Dr. Meyer wrote an opinion letter to a disability examiner in which the doctor limited Coan's ability to lift to ten pounds, her sitting to one hour at a time, and no bending, twisting, or squatting. However, the doctor noted these restrictions were only because of Coan's post-surgical status, and he deferred any permanent restrictions for three to six months, until she had a chance to recover fully from the surgery. (R. 452)

The record contains no other treatment records from any medical provider. On May 6, 2002, Donald J. Larson, M.D. reviewed Coan's records and completed a Physical Residual Functional Capacity Assessment form. (R. 458-67) He opined Coan could lift no more than ten pounds, both occasionally and on a regular basis. He opined she could stand, walk, and sit for about six hours in an eight-hour workday, with normal breaks, and push/pull without limitation. He noted she occasionally would be restricted in her ability to climb, stoop, kneel, crouch, and crawl, but noted these restrictions were temporary due to her surgery. He opined she would have no manipulative, visual, or communicative limitations. He opined she should avoid concentrated exposure to

extreme cold, vibration, and hazards, but otherwise she would have no environmental limitations. (R. 458-63)

In notes from his review of Coan's records, Dr. Larson found Coan to have medically determinable impairments of degenerative disc disease of the lumbosacral spine, status post laminectomy and fusion, and Hepatitis C. Although severe, he found these impairments did not meet or equal the Listings. He found Coan's allegations to be only partially credible, relying on Dr. Meyer's December 19, 2001, notation that he was skeptical about her overall desire to improve and comply. Giving Coan the benefit of Dr. Meyer's ten-pound lifting restriction, Dr. Larson found Coan would be limited to a narrow range of light work. (R. 466-67)

On August 13, 2003, Dr. Meyer examined Coan and completed a Physician's Confidential Report form in which he opined Coan's prognosis and rehabilitation potential were "fair." (R. 468) He noted she had severe pain in her lumbar spine, stiffness, and spasm, and she had decreased reflexes on the left. He listed her current medications as Oxycontin for pain, Xanaflex, and Motrin. He recommended ongoing physical therapy. Dr. Meyer gave Coan permanent restrictions of no lifting over ten pounds; no twisting, bending, or squatting; and no sitting for more than one hour at a time. (R. 468-69)

4. The ALJ's decision

The ALJ found Coan had not performed substantial gainful activity since March 1, 2001, her alleged onset date. (R. 18) She found Coan to have severe impairments including "a history of laminectomy, discectomy and fusion at L5-S1; and a history of hepatitis C[,]" but she found those impairments did not meet or equal the Listing criteria. (*Id.*)

The ALJ made a finding that Coan's history of abusing alcohol and other drugs was not a contributing factor material to a determination of disability. (*Id.*)

The ALJ noted Coan's medically determinable impairments "could possibly produce some pain or other symptoms," but found her allegations exceeded "the limitations reasonably expected from the medical findings." (R. 19-20) She discounted Coan's credibility based on inconsistencies in the records as a whole. These included the fact that Coan sat for thirty-five minutes at the hearing before she had to stand up due to numbness in her leg. The ALJ also noted Coan had testified she helped her mother with laundry and cooking, and while Coan was incarcerated, she had been able to spend a significant amount of time "reading magazines about homes and housekeeping and prayer books . . . reflect[ing] an ability to sit and concentrate." (R. 20)

The ALJ noted there was no evidence Coan had lost weight or experienced any diffuse atrophy or muscle-wasting, which the ALJ noted are two side effects from prolonged and/or chronic pain. The ALJ stated the absence of such evidence gave rise to an inference that although Coan "undoubtedly experiences some degree of pain, that pain has apparently not altered the use of her muscles and joints to the extent that it has resulted in diffuse atrophy or muscle-wasting." (*Id.*)

Like the consulting physician, the ALJ also pointed to Dr. Meyer's skepticism about Coan's "overall desire to improve and comply with medical advice." (*Id.*) The ALJ noted "the efficacy of any physician's treatment is only as good as the information provided and the degree of compliance exhibited," and the ALJ found Coan's "noncompliance does not support the alleged intensity and duration of pain and subjective complaints." (*Id.*)

The ALJ found Coan retained the residual functional capacity to perform work at the sedentary level. She found Coan could lift/carry up to ten pounds, both occasionally

and frequently; "stand and/or walk at least two hours with breaks during an eight hour workday, and sit continuously with breaks every two hours for about six hours in an eight hour workday with no bending, twisting or squatting, occasional climbing of ladders/ropes/scaffolds, kneeling, crouching, crawling and avoidance of concentrated exposure to extreme cold, vibration and hazards." (R. 20-21)

The ALJ noted she had given "substantial persuasive weight" to the opinions of Coan's treating physicians in reaching her assessment of Coan's functional abilities. The ALJ also gave "substantial weight" to the opinions of the consulting physicians. (R. 21)

The ALJ found Coan's "past relevant work as a telemarketer as described by [Coan] was at the sedentary level and allowed her to sit and stand at will. The evidence indicates [Coan] did well at this work." (*Id.*) Accordingly, the ALJ found Coan was capable of returning to her past relevant work and, therefore, Coan was not disabled. (*Id.*)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work

which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step sequential evaluation process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *Dixon v. Barnhart*, 353 F.3d 602, 605 (8th Cir. 2003); *Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner will consider a claimant's work activity. If the claimant is engaged in substantial gainful activity, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(i).

Second, if the claimant is not engaged in substantial gainful activity, the Commissioner looks to see "whether the claimant has a severe impairment that significantly limits the claimant's physical or mental ability to perform basic work activities." *Dixon*, 353 F.3d at 605; *accord Lewis v. Barnhart*, 353 F.3d 642, 645 (8th Cir. 2003). The United States Supreme Court has explained:

> The ability to do basic work activities is defined as "the abilities and aptitudes necessary to do most jobs." . . . Such abilities and aptitudes include "[p]hysical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling"; "[c]apacities for seeing, hearing, and speaking"; "[u]nderstanding, carrying out and remembering simple instructions"; "[u]se of judgment"; "[r]esponding appropriately to supervision, co-workers, and usual work situations"; and "[d]ealing with changes in a routine work setting."

Bowen v. Yuckert, 482 U.S. 137, 140-42, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119 (1987) (citing 20 C.F.R. §§ 404.1521(b), 416.921(b)).

Third, if the claimant has a severe impairment, then the Commissioner will consider the medical severity of the impairment. If the impairment meets or equals one

of the presumptively disabling impairments listed in the regulations, then the claimant is considered disabled, regardless of age, education, or work experience. 20 C.F.R. § 404.1520; *Kelley*, 133 F.3d at 588.

Fourth, if the claimant's impairment is severe, but it does not meet or equal one of the presumptively disabling impairments, then the Commissioner will assess the claimant's residual functional capacity ("RFC") to determine the claimant's "ability to meet the physical, mental, sensory, and other requirements" of the claimant's past relevant work. 20 C.F.R. §§ 404.1520(4)(iv); 404.1545(4); *see Lewis*, 353 F.3d at 645-46 ("RFC is a medical question defined wholly in terms of the claimant's physical ability to perform exertional tasks or, in other words, 'what the claimant can still do' despite his or her physical or mental limitations.") (citing *Bradshaw v. Heckler*, 810 F.2d 786, 790 (8th Cir. 1987); 20 C.F.R. § 404.1520(e) (1986)); *Dixon*, *supra*. The claimant is responsible for providing evidence the Commissioner will use to make a finding as to the claimant's RFC, but the Commissioner is responsible for developing the claimant's "complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [the claimant] get medical reports from [the claimant's] own medical sources." 20 C.F.R. § 404.1545(3). The Commissioner also will consider certain non-medical evidence and other evidence listed in the regulations. *See id*. If a claimant retains the RFC to perform past relevant work, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(iv).

Fifth, if the claimant's RFC as determined in step four will not allow the claimant to perform past relevant work, then the burden shifts to the Commissioner "to prove that there is other work that [the claimant] can do, given [the claimant's] RFC [as determined at step four], age, education, and work experience." Clarification of Rules Involving Residual Functional Capacity Assessments, etc., 68 Fed. Reg. 51,153, 51,155 (Aug. 26,

2003). The Commissioner must prove not only that the claimant's RFC will allow the claimant to make an adjustment to other work, but also that the other work exists in significant numbers in the national economy. *Id.*; 20 C.F.R. § 404.1520(4)(v); *Dixon, supra*; *Pearsall v. Massanari,* 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)); *Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000). If the claimant can make an adjustment to other work that exists in significant numbers in the national economy, then the Commissioner will find the claimant is not disabled. If the claimant cannot make an adjustment to other work, then the Commissioner will find the claimant is disabled. 20 C.F.R. § 404.1520(r)(v).

B. The Substantial Evidence Standard

The court reviews an ALJ's decision to determine whether the ALJ applied the correct legal standards, and whether the factual findings are supported by substantial evidence on the record as a whole. *Hensley v. Barnhart,* 352 F.3d 353, 355 (8th Cir. 2003); *Banks v. Massanari*, 258 F.3d 820, 823 (8th Cir. 2001) (citing *Lowe v. Apfel*, 226 F.3d 969, 971 (8th Cir. 2000)); *Berger v. Apfel*, 200 F.3d 1157, 1161 (8th Cir. 2000) (citing 42 U.S.C. § 405(g); *Richardson v. Perales*, 402 U.S. 389, 401, 91 S. Ct. 1420, 28 L. Ed. 2d 842 (1971)). This review is deferential; the court must affirm the ALJ's factual findings if they are supported by substantial evidence on the record as a whole. *Id.* (citing *Estes v. Barnhart,* 275 F.3d 722, 724 (8th Cir. 2002); *Krogmeier v. Barnhart,* 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel,* 201 F.3d 1010, 1012 (8th Cir. 2000)); *Kelley v. Callahan,* 133 F.3d 583, 587 (8th Cir. 1998) (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the

Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler v. Apfel*, 179 F.3d 1107, 1109 (8th Cir. 1999) (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier*, 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell*, 242 F.3d at 796; *Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)). The court must "search the record for evidence contradicting the [Commissioner's] decision and give that evidence appropriate weight when determining whether the overall evidence in support is substantial." *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (also citing *Cline*, *supra*).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does not "reweigh the evidence presented to the ALJ," *Baldwin*, 349 F.3d at 555 (citing *Bates v. Chater*, 54 F.3d 529, 532 (8th Cir. 1995)), or "review the factual record *de novo*." *Roe*

v. Chater, 92 F.3d 672, 675 (8th Cir. 1996) (citing *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *accord Baldwin*, 349 F.3d at 555; *Young v. Apfel*, 221 F.3d 1065, 1068 (8th Cir. 2000). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier*, 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse the Commissioner's decision "merely because substantial evidence would have supported an opposite decision." *Baldwin*, 349 F.3d at 555 (citing *Grebenick v. Chater*, 121 F.3d 1193, 1198 (8th Cir. 1997)); *Young*, 221 F.3d at 1068; *see Pearsall*, 274 F.3d at 1217; *Gowell*, 242 F.3d at 796; *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.*, 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen*, 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.*, 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*,

900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;
> 5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

IV. ANALYSIS

Coan argues "the ALJ erred in at least two respects: (1) In failing to find Coan credible, and (2) By failing to consider the impact of Coan's need to lie down as well as alternate between sitting and standing." (Doc. No. 8, p. 5) She attacks the ALJ's conclusion that there were inconsistencies between Coan's subjective complaints and the record. She notes the ALJ relied on the fact that Coan sat for thirty-five minutes during the hearing before she had to get up due to leg numbness. Coan argues this finding is not inconsistent with the record because she "often mentioned to her treating doctors that her pain went to her legs and feet." (*Id.*, citing R. 257, 314, 452)

She argues the ALJ's finding that Coan was able to help her mother with laundry and cooking was taken "completely out of context in implying that Coan could do these

activities with no limitations." (*Id.*) She notes that in her actual testimony, Coan stated she occasionally would "try to cook meals" or help her mother "fold laundry," but she stated "pretty much [she] really didn't get up and do a lot." (*Id.*, p. 6, citing R. 59-60)

She argues that in relying on Coan's ability to read all day in finding she retains the ability to sit and concentrate, "the ALJ took Coan's statements far beyond where a reasonable fact-finder would take them." (*Id.*, p. 6) Coan quotes from her testimony regarding her activities while she was incarcerated, noting she reads when she can, lies down when the pain becomes too great, has coffee, showers, and the like. (*Id.*, citing R. 59)

Thus, Coan argues there are no inconsistencies between her testimony and the medical records, and she maintains the record contains evidence that her pain complaints were not exaggerated. She argues the ALJ erred in discounting Dr. Meyer's opinion regarding Coan's limitations. (*Id.*, pp. 6-7, citing R. 318, 452) Dr. Meyer opined Coan should not (1) sit for more than one hour at a time;(2) twist, bend, or squat; and (3) lift more than ten pounds. (R. 469)

The restrictions proposed by Dr. Meyer are not consistent with the ALJ's assessment of Coan's residual functional capacity. The ALJ found Coan could sit continuously for two hours at a time. (R. 20-21; R. 21-22 ¶ 6) She further found Coan could return to her past job as a telemarketer because, as Coan performed the job, Coan was able to change positions from sitting to standing at will. Because she found Coan could return to her past relevant work, the ALJ did not proceed to the fifth step of the sequential evaluation process.

Nevertheless, the ALJ noted she was giving the opinions of Coan's treating physicians "substantial persuasive weight." (R. 21) It is not clear, therefore, why the ALJ found Coan able to sit for two hours at a time. That conclusion is further puzzling

given the complete absence of evidence regarding Coan's condition and treatment between the time Dr. Meyer made his first "temporary" assessment of Coan's limitations, soon after Coan's January 2002 surgery, and the time he assigned "permanent" limitations, in August 2003. Indeed, the record contains *no* evidence regarding Coan's condition and treatment from February 2003 to the date of the ALJ's decision on January 12, 2004.

At the hearing, Coan testified she had been seeing a Dr. Swanson at Mercy Medical Center. The ALJ noted she did not have records from Dr. Swanson as part of the record in this case. It appears that neither Coan nor the ALJ followed up to get Dr. Swanson's records. The ALJ also took no action to obtain an evaluation of Coan's condition that was current as of the time of the hearing. Even the most recent evaluation by a consulting physician occurred some eighteen months prior to the ALJ hearing. Given the lack of medical evidence of Coan's condition, the only evidence before the ALJ was the testimony of Coan and her daughter. Their allegations regarding Coan's functional abilities remains unrebutted on this record.

"It is the ALJ's duty to develop the record fully and fairly, even in cases in which the claimant is represented by counsel[,]" *Dozier v. Heckler*, 754 F.2d 274, 276 (8th Cir. 1985), although it is of some relevance that Coan's attorney did not obtain Coan's records for the period of almost two years between February 2002 and January 2004. *See Onstad v. Shalala*, 999 F.2d 1232, 1234 (8th Cir. 1993). The relevant question here is "whether medical evidence already in the record provides a sufficient basis for a decision in favor of the Commissioner." *Scott v. Apfel*, 89 F. Supp. 2d 1066, 1076 (N.D. Iowa 2000) (Bennett, C.J.). In considering whether an ALJ has failed to develop the record fully, the relevant inquiry is whether the claimant "was prejudiced or treated unfairly by how the ALJ did or did not develop the record; absent unfairness or prejudice, we will not

remand." *Onstad*, 999 F.2d at 1234 (citing *Phelan v. Bowen*, 846 F.2d 478, 481 (8th Cir. 1988)).

Coan has not argued she was prejudiced by the ALJ's failure to obtain and consider records of Coan's treatment and condition for the nearly two-year period prior to the hearing. Nevertheless, the court finds prejudice exists simply because the lack of evidence renders the record insufficient to support the ALJ's decision. Indeed, on the current record, the evidence supports reversal. Coan testified she lives basically a sedentary life. She is unable to do much more than care for her own hygiene. She reads, and does a limited amount of cooking. She occasionally helps her mother fold laundry. Before she moved in with her mother, Coan's teenaged children did the heavy chores around the house and helped her on a daily basis.

Coan's work history indicates she earned over $5,000 in five of the six years immediately preceding her disability onset date. (*See* R. 114) She evidenced a desire to return to work while she was being treated for her back problems, but her doctor advised her to stay off work until further evaluation was completed. (R. 399)

Both the ALJ and the consulting physician relied on Dr. Meyer's skepticism about Coan's "overall desire to improve and to comply." (R. 454) Specifically, Dr. Meyer noted, "[Coan's] pain is such that I believe that even though I am somewhat skeptical about her overall desire to improve and to comply, I feel we have no choice but to proceed with removal of the hardware and exploration of the right L5 nerve root." (*Id.*) This statement implies Dr. Meyer was skeptical about Coan's ongoing complaints of pain. However, when he performed surgery to remove Coan's hardware, the doctor discovered one of the pedicle screws had been broken off, the right L5 nerve root was encased in dense scar tissue, there was significant pressure on the L5 nerve root from an osteophyte, the nerve was densely adherent to the scar tissue and there was significant encroachment

of the origin of the L5 nerve root on one side, and there was significant synovitis and synovial hypertrophy of the right L4-5 facet joint. (R. 451) Dr. Meyer's findings during the surgical procedure confirmed Dr. Cook's earlier speculation that there was significant scar tissue narrowing the epidural space. Further, the surgical findings support Coan's complaints of ongoing pain during the two years preceding the surgery.

Dr. Meyer made no further notations in his records to indicate continued skepticism regarding Coan's complaints. He examined her in August 2003, for purposes of completing the disability form, and assigned a permanent lifting limitation of ten pounds, no sitting for more than one hour, and no twisting, bending, or squatting. (R. 469) In addition, except for the single notation preceding Coan's surgery, Dr. Meyer never opined that Coan was exaggerating her pain or was being less than truthful or forthcoming about her condition.

The court further finds the ALJ's statements about Coan's noncompliance with medical advice to be unsupported by the evidence of record. Coan had one or two missed appointments between November 2000 and August 2003, but each of those was rescheduled promptly. It appears she took her prescribed medications, and she complied with doctors' orders regarding work restrictions. The only apparent evidence of any noncompliance was when Dr. Meyer, on April 3, 2001, directed Coan to return for a follow-up visit in three to four weeks, but she did not see him again until September 2001. (*See* R. 425-26, 423-24) However, in the interim, Coan called Dr. Meyer's office on April 5, 2001, to report on her condition (R. 425); she called for a medication refill on April 24, 2001 (R. 424); and she saw Dr. Holtz for follow-up of her condition on May 4, 2001 (R. 414); May 15, 2001 (R. 404-05); May 30, 2001 (R. 403); June 25, 2001 (*Id.*); and July 23, 2001 (R. 399). She also underwent an MRI of her lumbar spine on July 18, 2001 (R. 401-02). The court finds the record does not contain substantial evidence to

support the ALJ's assertion that Coan failed to comply with her doctors' orders. (*See* R. 20)

On this record, the court finds the ALJ's opinion is not supported by substantial evidence. The court finds the opposite to be true -- *but only for the period through June 2002*; *i.e.*, a period of time six months after Coan's surgery. Dr. Meyer indicated it would take three to six months for Coan to recover completely. For the period through June 2002, the court finds Coan was unable to return to her past relevant work, and the ALJ should have gone forward with step five of the evaluation. However, for the period from July 2002 through January 2004, the court finds the record contains *no* evidence that would allow the ALJ to make any determination regarding Coan's residual functional capacity and ability to perform work at the substantial gainful activity level.

Accordingly, the court recommends the Commissioner's decision be reversed and this case be remanded for further development of the record regarding Coan's condition and treatment from and after her January 2002 surgery, and for evaluation of Coan's claim through step five of the evaluation process.

IV. CONCLUSION

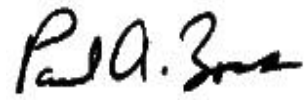
For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[7] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that the Commissioner's decision be

[7]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

reversed, judgment be entered for the plaintiff, and this matter be remanded pursuant to sentence four of 42 U.S.C. § 405(g), for further proceedings consistent with this opinion.

IT IS SO ORDERED.

DATED this 1st day of April, 2005.



PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT